Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6014120 11/20/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **792 NORTH MAIN ILLINOIS VETERANS HOME - ANNA** ANNA, IL 62906 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 000 Initial Comments S 000 Complaint Investigation # 1958444/IL117578 \$9999 Final Observations S9999 Statement of Licensure Violations 340.1440a) 340.1505a) 340.1505b) 340.1505e) Section 340.1440 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) Section 340.1505 Medical, Nursing and Restorative Services a) Comprehensive resident care plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident 's care needs. The assessment shall be developed with the active participation of the resident and the Attachment A resident 's guardian or representative, as Statement of Licensure Violations applicable. b) The facility shall provide the necessary care

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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open area mid ear and one on the Apex of ear. Wound nurse aware"Another progress note dated November 4, 2019 at 8:57 PM for R2 states, "Holding (Ketoconazole Cream) due to ears are very red and swollen and have breakdown forming due to being bedridden. Protective egg crate applied to help with pressure." A review of R2's physician orders reveals no interventions related to relieving pressure on R2's ears. R2's Care Plan lists an initiated focus area on 9/30/16 of R2 being at risk of skin impairment related to incontinence and impaired mobility and says on 9/11/19, R2 has a stage II on his left inner heel that was resolved on 9/25/19. Under this same care plan focus area, R2 has listed another stage II bilateral ears on 11/5/19 and lists under interventions for R2 to be turned and repositioned every 2 hours in bed. Use a draw sheet. This intervention has an initiated date of 5/10/19, Another intervention is listed as weekly skin checks with an initiated date of 10/5/16. This same care plan lists no interventions related to protecting R2's ears from pressure. On 11/19/19 at 1:32 PM, V2 (Director of Nursing) said she requested V4 (Registered Nurser(RN) change R2's ear pressure sores from unavoidable to avoidable on the pressure ulcer weekly status report due to the fact, when he re-admitted into the facility from the hospital, R2 did not have the pressure lipriries on his ears. R2 at the time, had diarrhea bad, and his buttocks were very excorriated. The staff at the facility was turning (R2) from side to side to prevent his buttocks were very excorriated. The staff at the facility was turning (R2) from side to side to prevent his buttocks were very excorriated. The staff at the facility was turning that time period (R2) obtained the pressures to		

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FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ C B. WING IL6014120 11/20/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **792 NORTH MAIN ILLINOIS VETERANS HOME - ANNA** ANNA, IL 62906 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S9999 Continued From page 4 his ears. On 11/19/19 at 3:30 PM, V4 (RN) verified interventions needed to be put into place to prevent pressures from forming on R2's ears and reported R2 was having several loose stools from having C'diff (Clostridium Difficile, a condition causing several loose and runny stools), and R2 was being turned every 2 hours due to his bottom being really irritated, and we did not think his ears would break down that quickly." On 11/20/19 at 11:50 AM, V4 said there were alternating air pressure mattresses available in the facility, but R2 does not have one, then stated "I am surprised Hospice has not brought one in for him." (B)